

(5) Number of patients trained for the current year and the prior 2 years on a monthly basis.

(6) Projection for the next 12 months of future training candidates.

(7) The number and qualifications of staff at training sessions.

(f) *Accelerated training exception.* (1) An ESRD facility may bill Medicare for a dialysis training session only when a patient receives a dialysis treatment (normally three times a week for hemodialysis). Continuous cycling peritoneal dialysis (CCPD) and continuous ambulatory peritoneal dialysis (CAPD) are daily treatment modalities; ESRD facilities are paid the equivalent of three hemodialysis treatments for each week that CCPD and CAPD treatments are provided.

(2) If an ESRD facility elects to train all its patients using a particular treatment modality more often than during each dialysis treatment and, as a result, the number of billable training dialysis sessions is less than the number of actual training sessions, the facility may request a composite rate exception, limited to the lesser of the—

(i) Facility's projected training cost per treatment; or

(ii) Cost per treatment the facility would have received in training a patient if it had trained patients only during a dialysis treatment, that is, three times per week.

(3) An ESRD facility may bill a maximum of 25 training sessions per patient for hemodialysis training and 15 sessions for CCPD and CAPD training.

(4) In computing the payment amount under an accelerated training exception, HCFA uses a minimum number of training sessions per patient (15 for hemodialysis and 5 for CAPD and CCPD) when the facility actually provides fewer than the minimum number of training sessions.

(5) To justify an accelerated training exception request, an ESRD facility must document that a significant number of training sessions for a particular modality are provided during a shorter but more condensed period.

(6) The facility must submit with the exception request a list of patients, by modality, trained during the most recent cost report period. The list must include each beneficiary's—

(i) Name;

(ii) Age; and

(iii) Training status (completed, not completed, being retrained, or in the process of being trained).

(7) The total treatments from the patient list must be the same as the total treatments reported on the cost report filed with the request.

**§ 413.192 Payment exception: Frequency of dialysis.**

(a) *Qualification.* To qualify for an exception to the prospective payment rate based on frequency of dialysis, the facility must establish that it has a substantial portion of outpatient maintenance dialysis treatments furnished to patients who dialyze less frequently than three times per week.

(b) *Definition.* For purposes of this section, "substantial" means the number of treatments furnished by the facility is at least 15 percent lower than the number would be if all patients dialyzed three times a week.

(c) *Limitation for per treatment payment rates.* Per treatment payment rates granted under this exception may not exceed the amount that produces weekly payments per patient equal to three times the facility's prospective composite rate, exclusive of any exception amounts.

(d) *Documentation.* To document that an ESRD facility furnishes a substantial number of dialysis treatments at a frequency less than three times per week per patient, the facility must submit the following information:

(1) A list of patients receiving outpatient dialysis treatments for the cost report that is filed with the request. The list must indicate—

(i) Whether the patients are permanent, transient, or temporary;

(ii) The medically prescribed frequency of dialysis; and

(iii) The number of dialysis treatments that each patient received on a weekly and yearly basis and an explanation of any discrepancy between that calculation and the number of treatments reported on the facility's cost report.

(2) A list of patients used to project treatments. The list must indicate—

(i) Whether the patients are permanent, transient, or temporary;

(ii) The medically prescribed frequency of dialysis;

(iii) The number of dialysis treatments that each patient is projected to receive on a weekly and yearly basis, an explanation of any discrepancy between that calculation and the number of treatments reported on the facility's projected cost report, and an explanation for any change among prior, actual, and projected data.

(3) A schedule showing the number of treatments to be furnished twice a week and the number of treatments that would have been furnished if each patient were dialyzed three times a week.

(4) A computation of the facility's projected costs per treatment using the—

(i) Projected number of treatments furnished twice a week; and

(ii) Number of treatments if patients dialyze three times a week.

(5) A schedule showing the computation of the percentage decrease in the number of treatments.

**§413.194 Appeals.**

(a) *Appeals under section 1878 of the Act.* (1) A facility that disputes the amount of its allowable Medicare bad debts reimbursed by HCFA under §413.178 may request review by the intermediary or the Provider Reimbursement Review Board (PRRB) in accordance with subpart R of part 405 of this chapter.

(2) A facility must request and obtain a final agency decision prior to seeking judicial review of a dispute regarding the amount of allowable Medicare bad debts.

(b) *Other appeals.* (1) A facility that has requested higher payment per treatment in accordance with §413.180 may request review from the intermediary or the PRRB if HCFA has denied the request in whole or in part. In such a case, the procedure in subpart R of part 405 of this chapter is followed to the extent that it is applicable.

(2) The PRRB has the authority to review the action taken by HCFA on the facility's requests. However, the PRRB's decision is subject to review by the Administrator under §405.1875 of this chapter.

(3) A facility must request and obtain a final agency decision, in accordance with paragraph (b)(1) of this section, prior to seeking judicial review of the denial, in whole or in part, of the exception request.

(c) *Procedure.* (1) The facility must request review within 180 days of the date of the decision on which review is sought.

(2) The facility may not submit to the reviewing entity, whether it is the intermediary or the PRRB, any additional information or cost data that had not been submitted to HCFA at the time HCFA evaluated the exception request.

(d) *Determining amount in controversy.* For purposes of determining PRRB jurisdiction under subpart R of part 405 of this chapter for the appeals described in paragraph (b) of this section—

(1) The amount in controversy per treatment is determined by subtracting the amount of program payment from the amount the facility requested under §413.180; and

(2) The total amount in controversy is calculated by multiplying the amount in controversy per treatment by the projected number of treatments for the exception request period.

**§413.196 Notification of changes in rate-setting methodologies and payment rates.**

(a) HCFA or the facility's intermediary notifies each facility of changes in its payment rate. This notice includes changes in individual facility payment rates resulting from corrections or revisions of particular geographic labor cost adjustment factors.

(b) Changes in payment rates resulting from incorporation of updated cost data or general revisions of geographic labor cost adjustment factors are announced by notice published in the FEDERAL REGISTER without opportunity for prior comment. Revisions of the rate-setting methodology are published in the FEDERAL REGISTER in accordance with the Department's established rulemaking procedures.